# The IHS Strategic Plan:
## *Improving the Health of American Indian and Alaska Native People Through Collaboration and Innovation*

**MISSION:**

***The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.***

**GOAL:**

***To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.***

**FOUNDATION:**

***To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.***

### I. Introduction

Since its inception in FY 1955, the Indian Health Service (IHS) has been the agency within the Department of Health and Human Services responsible for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN). The IHS assumes this responsibility with a high level of passion and commitment. The IHS provides comprehensive health services through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. This "Indian Health System" currently serves approximately 1.5 million AI/AN people through 49 hospitals, 221 health centers, 120 health stations, 100 Alaska village clinics, 34 urban Indian projects, and 6 tribal epidemiology centers.

This IHS Strategic Plan is the product of a diverse group of IHS stakeholders, charged by IHS leadership to develop a comprehensive and systematic approach to the realization of the IHS Mission, Goal, and Foundation over the current decade.

To accomplish these bold challenges, the Strategic Planning Workgroup brought together expertise in clinical care, public health, epidemiology, health care administration, health care financing, community development, tribal sovereignty, legislation, education, environmental health, and facilities construction, with representation from:

- IHS local, Area Office, and Headquarters staff
- Tribal health leadership
- Urban Indian health leadership
- HHS Office of the Secretary
- The Friends of Indian Health
- The Tribal Self Governance Advisory Committee
- The National Indian Health Board

The development of this plan was predicated upon a systematic assessment of the strengths, weaknesses, threats, opportunities, health trends, statutory and regulatory issues, and current and projected funding of the Indian health care system. During this process, the workgroup collectively came to the realization that the long-term success of the IHS was largely dependent on effective collaboration and synergism between the IHS and its diverse stakeholders. The realization of the

Mission, Goal and Foundation is not achievable without this collaboration.

The success of this Plan is dependent on the following strategic organizational components that currently exist, and are referenced in this plan:

The **Indian health network** represents the IHS and the critical partners who share a responsibility or interest in the health of the AI/AN population. This network includes tribes, tribal organizations, Indian urban organizations, other Federal agencies, state agencies, city and county governments, colleges and universities and private organizations as well as others.

The **Indian health system** consists of the IHS, tribal, and urban (I/T/U) operated facilities and programs with support and coordination provided by IHS Headquarters, 12 IHS Area Offices, and six Tribal Epidemiology Centers.

The **I /T/U system** is comprised of the local health delivery programs.

IHS must serve a leadership and coordinating role in expanding and improving the increasingly diverse Indian health network to effectively pursue strategic opportunities. Again, it is the consensus of the workgroup that this collaboration is essential to achieving the IHS Mission, Goal, and Foundation

## II. Background

The Federal responsibility for AI/AN health care is grounded in treaty obligations, case law, the Snyder Act (P.L. 83-568), the Indian Health Care Improvement Act (P.L. 94-437), as well as historical obligations for the health of AI/AN people.

Many of the people served by the Indian Health System live in the most remote and poverty stricken areas of the United States.The health disease burden of AI/AN people is historically greater that that of US all races. Despite major improvements in life expectancy over the past 4 decades, recent statistics indicate that current life expectancy is decreasing for AI/AN people.

The health services provided by the I/T/U system often represent the only source of health care. The range of services provided by the I/T/U system includes emergency, inpatient and ambulatory care, environmental and community services, and a diversity of health promotion, disease prevention and public health activities. In addition, various health care and referral services are provided to Indian people away from the reservation settings through urban Indian health programs.

### *How We Have Transformed*

In 1955, the IHS was transferred from the Department of Interior/Bureau of Indian Affairs to the HHS. This transfer began the HHS relationship with tribal nations that is based on tribal sovereignty and a government-to-government relationship. In this context, sovereignty means that tribes can govern their own territory and internal affairs and only Congress can override an Indian nation's authority. The government-to-government relationship is a Federal policy that requires the U.S. Government to consult with tribes about how Federal actions may affect them.

Between the years 1955-74, the IHS provided health care to the AI/AN population through the use of Civil Service and Commissioned Corps Federal personnel systems. However, in 1975 this pattern began to change with the passage of the Indian Self-Determination and Education Assistance Act that gave tribes the

option of assuming the management of health programs in their communities and authorized funding for improvements in tribal capacity to contract under this Act.
This Act was amended in 1992 to authorize the Secretary of HHS to negotiate Self-Governance compacts with tribes as part of the Self-Governance Demonstration Project to strengthen the government-to-government relationship between Federal and Tribal governments and reduce Federal control over decision making and enhance fiscal control, resource allocations and management at the tribal level. Thus, the amended Act provided tribes three options to exercise their sovereign rights:

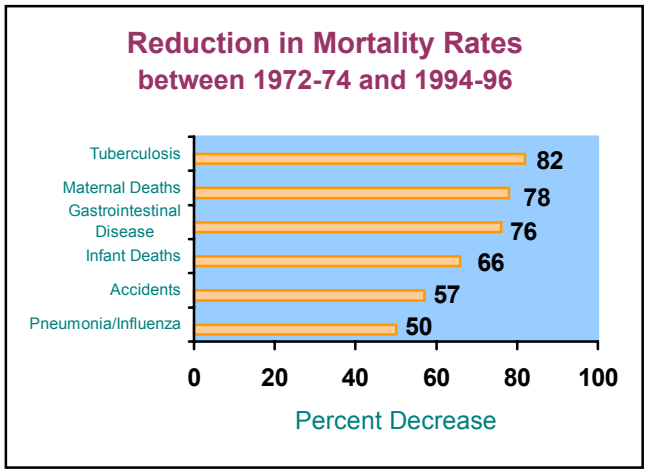
1. Title I Contract
2. Title V Compact
3. Retain federally operated health programs

Tribes who elect to contract or compact for the management of their health programs have the opportunity to redesign these programs to meet their specific needs and implement innovation solutions.

Today the role of the I/T/U partnership is an accepted and valued part of our organizational culture. This partnership has contributed to our effectiveness in budget formulation, performance planning, and overall Indian health advocacy. It is essential to continue and expand upon these changes. This strategic plan can serve as a road map for this critical process.

***What We Have Accomplished***

- Despite limited resources, IHS has effectively demonstrated the ability to utilize available resources to improve the health status of the AI/AN people through applying principles of public health and community-based interventions as well as providing comprehensive health services. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96 as illustrated by the following graph:




These improved outcomes have been achieved despite the following complicating factors:

- lower per capita expenditures for health care (i.e., estimated to be less than 60 percent of national level when IHS, third party, and out of pocket are combined for AI/ANs)
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)
- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower availability of health care

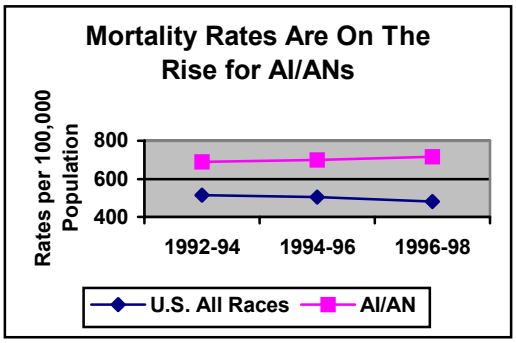
services (e.g., 25% annual availability of dental service for AI/ANs compared to about 60% for US population overall)

- significantly higher health care needs because of higher disease burden (including epidemic rates of diabetes- more than 50% of adults in some communities are diagnosed with diabetes, alcoholism, injuries, oral diseases, and overall death rate)

- high unemployment, poverty, substandard housing, and other inadequate social determinants of health

***What We Face***

While the Indian health system documented significant improvements in the health of the AI/AN population through the early 1990's, the trend more recently represents the greatest concern. AI/AN mortality data from FY1996-1998 shows INCREASING death rates from diabetes, cancer, heart disease, suicide and injuries. These increases have resulted in an overall increase in the death rate for AI/ANs while the rates for the nation as a whole have been dropping.




The disparity in health status between the AI/AN population and the general population is widening. Clearly, declines in per capita funding for health care, loss of access to services, diminished public health supportive infrastructure, continued high rates of poverty, and the high prevalence of lifestyle patterns that compromise health have all contributed to these statistics. While improved access to new and innovative clinical care can help reverse this trend, new culturally appropriate health promotion and disease prevention initiatives will also be essential. These initiatives must go beyond the walls of our clinics to empower and positively influence individual, family and community health behavior.

***Strategic Outlook***

This strategic plan is based upon a systematic assessment of the health care environment in which the IHS functions. This evaluation led to the identification of five critical planning assumptions that are the basis for the development of this plan. These assumptions are:

**1. Health care costs continue to increase.**

As disease burden increases in AI/AN communities, the cost of providing appropriate quality health care services continues to rise. One example is diabetes. The IHS has consistently provided excellent, if limited, care to our diabetes population. However, as the number of diabetic patients continues to increase, the costs to provide quality care as well as adequate pharmaceutical benefits to these patients amplifies.

Cost effective health promotion/disease prevention activities are necessary to address these increasing treatment costs. However, to a large extent, only significant changes in lifestyles will bring about the prevention of these diseases and conditions. These lifestyle changes require an educational and supportive infrastructure that is culturally sensitive

and extends far beyond the walls of health clinics to reach people in their community and family settings.

**2. Future increases in appropriated funding for the IHS are uncertain.**

Changes to the budget formulation process, including the integration of local tribal and regional involvement in GPRA planning, appear to have helped increase recent IHS appropriations. However, it is unclear if these necessary and essential funding increases will continue.

We must continue advocacy efforts in partnership with our stakeholders to try and leverage these necessary enhancements. Regardless of what the national priorities are at any time, IHS must promote the ongoing importance of the I/T/U system in the lives of AI/AN's as well as the nation's overall health. In addition, we must focus on increasing efficiency and effectiveness, as well as quality, in our health care delivery. Particular emphasis must be given to increasing collections through effective business planning and securing alternative resources for pilot projects, treatment, and staff development.

**3. The proportion of resources directly under the control of the IHS will decrease.**

Consistent with the intent of the Indian Self-Determination Act, tribally managed health programs now represent over half of the IHS budget for health service and that proportion is likely to grow. In the face of continued downsizing of IHS Area and Headquarters offices, it is critical that the IHS identify ways to maintain and strengthen capacity to effectively advocate for the health needs of AI/AN people and coordinate the ongoing efforts to expand the Indian health network to bring new knowledge, technology, and funding to the Indian health system.

An essential part of effective advocacy depends upon the IHS's ability to meet the growing accountability requirements with accurate, credible, and reliable data compiled from the I/T/U realm. This requirement necessitates the acquisition of enhanced IT capacity across the Indian health systems, with an IT infrastructure supported through shared resources.

To continue to succeed, IHS needs to embrace a more entrepreneurial culture and expand partnerships and coalitions, an approach successfully used by many tribal and urban programs. As part of this process, the IHS must reinforce its commitment to public health principles through assuring that adequate public health capacity is available to the Indian health system.

**4. The Indian health system must be able to assure adequate organizational capacity and expertise.**

IHS must assure that we have the organizational capacity and expertise to meet our human resource needs; this requires our ability to hire competent well trained staff and support the development of current staff within the system through orientation, job experience, mentoring, and long and short term training experiences.

Historically, it has been difficult to adequately address these Ongoing problems in recruiting and retaining qualified health care providers and placing experienced, qualified staff in administrative and leadership positions remain. Furthermore, there has been a loss of organizational memory from the continued retirement of seasoned professionals without mentored and experienced staff to replace them.

We must become more successful at human resource development at all

levels of the Indian health care system to meet our mission and goal.

5. **The need for appropriate information technology and accurate, credible data is increasing.**

The capacity to collect, compile, and report health status, workload, and financial data that is credible is not an option but a necessity to:

- monitor health status and manage and evaluate the costs and effectiveness of health programs
- meet Federal accountability requirements that are increasingly connected to maintaining and enhancing resources.
- effectively advocating for resources that are increasingly linked to the growing Federal accountability requirements.

Effective and efficient investments in developing information technology capabilities is mission-critical to the IHS and its stakeholders; our current rate of investment in this development process will need to increase to collectively address these growing data demands and the ability to effectively advocate for AI/AN health care.

## *Response: The IHS Strategic Plan*

The IHS Strategic Plan Workgroup believes that these five challenges present a unique opportunity. This Strategic Plan is designed to offer appropriate, innovative and successful responses to these critical planning assumptions. The proposed Plan contains four Strategic Goals and necessary appendices. The four overarching strategic goals are as follows:

1. **Build Healthy Communities**
2. **Achieve Parity in Access by 2010**
3. **Provide Compassionate Quality Health Care**
4. **Embrace Innovation**

Each strategic goal is composed of several specific objectives that include a discussion of ***Purpose and Outcome***, ***Strategies and Processes***, and a list of potential ***Performance Measures*** to assess progress in reaching each objective. The Strategic Planning Workgroup hopes that this plan will help guide the Indian Health Service as the Indian Health Network continues to embrace change and innovation in health care for AI/AN people in the 21st century.

# STRATEGIC GOAL 1
# Build Healthy Communities

**OBJECTIVE 1.1**

Mobilize AI/AN communities to promote wellness and healing

**OBJECTIVE 1.2**

Develop and support community and public health infrastructure

**OBJECTIVE 1.3**

Ensure access to information and technical expertise to define and characterize the community, identify the community health problems, and monitor the effectiveness of community interventions.

Public Health has been described as what we do collectively to assure the conditions in which people can be healthy. The notion of "community" represents the most important component of the "we" and profoundly influences the "conditions" that ultimately determine the health of people.

***Objective 1.1***

***Mobilize AI/AN communities to promote wellness and healing***

## PURPOSE AND OUTCOME

Health is profoundly influenced by behaviors occurring at the community level. Despite continued technological advances in medical science, the most powerful determinants of health and well-being remain how and what we consume, how we care for our bodies in terms of exercise and sleep and personal hygiene, our exposure to disease and injury, social determinants and the nature of our relationships with others rather than access to state-of-the-art health services. The finest hospital care will have little impact on life expectancy, infant mortality, or the prevalence of chronic disease without the support of a public health system that works in the community to promote healthy behaviors, prevent disease, and create a healthy environment for all of us.

For example, the steady decline of cardiovascular deaths that has occurred in the US since 1970 has been attributed to the synergy of a number of changes, including: increased public awareness of the importance of diet, exercise, and cholesterol level; awareness of signs and symptoms of heart disease; improved EMS services; advances in hospital-based cardiac care, and decreases in tobacco use and air pollution.

For these reasons, the IHS has embraced the concept of community oriented primary care (the COPC model) as an essential part of improving community health. This approach is based on a proactive, collaborative approach between the local health care system and the community that includes four critical processes:

1. Defining and characterizing the community.
2. Identifying community health problems.
3. Developing emphasis areas by planning/modifying the health program.
4. Monitoring the effectiveness of the program modifications

Experience in Indian Country has shown that the COPC model is the most effective approach to treating and preventing the major health problems confronting AI/AN communities, including diabetes, heart disease, obesity, and alcoholism. Indian Health Service staff can play a central role by mobilizing individuals and empowering communities to promote wellness and healing as an essential part of this effort. Success of this endeavor requires broad community based partnerships, including tribal governments, schools, WIC, Head Start, sanitation, IHS and others. It also requires public health infrastructure, adequate data collection capacity, and technical assistance that are addressed in Objectives 1.2 and 1.3 which follow.

The expected interim outcome is improved community involvement in health planning, health promotion and health delivery. Long-term outcomes include increased rates of healthy behaviors, improved health status within

communities, decreased rates of chronic disease, and improved life expectancy.

## STRATEGIES AND PROCESSES

As a community expert in health, IHS fulfills a unique role. IHS can provide technical assistance and leadership as well as advocacy on health care issues to communities as well as organizations.

### Involvement in community health initiatives

There is an ongoing need for IHS employees to provide leadership, technical expertise, and support to community health initiatives.

**Strategies**:

1. At the Headquarters, Area and Service Unit levels, IHS supports and encourages ongoing involvement of IHS employees in community based assessment and health promotion initiatives; evaluation standards are written to include community involvement as an element of employees' performance appraisals.
2. IHS provides ongoing support for the Head Start initiative. This ensures appropriate training for this program at local levels (Head Start programs offer one of the best opportunities for early prevention of childhood obesity and establishing a healthy lifestyle).
3. IHS continues to promote model programs and demonstration sites, such as the Zuni Wellness Project.
4. IHS shares best practice guidelines for community health initiatives via the Web and other media.
5. IHS seeks to continue special initiative funding, for instance for diabetes, throughout Indian country.

### Ongoing support for wellness and healing in AI/AN communities

Many programs exist that support health promotion and disease prevention across I/T/U setting. The success of these programs is dependent upon a collaborative approach to development and implementation of appropriate strategies.

**Strategies**:

1. IHS supports a collaborative approach to the development of community health and wellness initiatives
2. IHS provides ongoing support to the diabetes grant initiatives
3. IHS integrates/increases opportunities for local community participation in performance planning at IHS run facilities
4. IHS works to ensure adequate dissemination of successful community-based interventions in a timely manner

**PERFORMANCE MEASURES**

1. Monitor the number of model COPC I/T/U program sites per annum.
2. Development of Web site to share community helth COPC initiatives.

***OBJECTIVE 1.2***

***Develop and support community and public health infrastructure***


## PURPOSE AND OUTCOME

The health of a community is dependent upon an appropriate and adequate public health infrastructure. IHS has a long history of providing certain public health services, such as public health nursing, the Community Health Representative (CHR) program, environmental health and sanitation services, injury prevention and others. In addition, IHS has been closely engaged with many other State, Federal, and Tribal programs throughout the life cycle from WIC to nursing home care. This complex network of programs and services comprises the "public health infrastructure" and supports the core public health functions of assessment, assurance, and policy development.

### The Ten Essential Services of Public Health

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, empower people about health issues.
4. Mobilize community partnerships and coalitions to identify and solve health issues.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and public health services.
10. Research for new insights and innovative solutions to health problems.

*James A. Harrell, Office of Disease Prevention, Washington, D.C. Edward L. Baker, MD, MPH, Centers for Disease Control and Prevention, Atlanta, Georgia* and the *Essential Services Work Group*. Members of the *Essential Services Work Group* included representatives from the Association of State and Territorial Health Officials, National Association of County and City Health Officials, Institute of Medicine (National Academy of Sciences), Association of Schools of Public Health, Public Health Foundation, National Association of State Alcohol & Drug Abuse Directors, National Association of State Mental Health Program Directors, and Public Health Services.

IHS must continue to be an active partner with Tribes to ensure that the public health infrastructure is adequate to deliver essential public health services to AI/AN communities. This does not mean that IHS will necessarily be the primary provider of each of these services, but rather that IHS has a vested interest and must be engaged with other partners in the process.

The expected interim outcome is increased advocacy support capacity for public health at the local level. In addition, local communities increase their ability to participate in a public health assessment. and the implementation of the COPC Model. The expected long- term outcome is an improvement in the local public health infrastructure, resulting in improved health status for AI/AN communities.

**STATEGIES AND PROCESSES**

The IHS, as a public health agency, is responsible for helping ensure that an adequate public health infrastructure exists that supports the local I/T/U system. In order to fulfill this responsibility, the IHS must be attentive to the public health roles of assessment, assurance and advocacy. In addition, the IHS must specifically implement strategies to help meet the ten essential public health services now recognized in the USA (see previous page).

**Assess the state of the public health infrastructure**

Public health capacity and expertise is a critical component of community health. IHS service areas and tribal communities must be able to assess their public health infrastructure and recognize the capabilities and gaps within their system. Tools to measure baseline and progress are essential for this assessment of public health infrastructure.

**Strategies:**

1. IHS assists the I/T/Us in education, selection and use of appropriate tools to assess their public health infrastructure.
2. IHS supports the distribution and implementation of current community health assessment models. IHS helps identify and make resources available for technical assistance and training so that Indian communities successfully utilizes these instruments to document and monitor their overall health status.
3. IHS, in conjunction with CDC and tribal epidemiology centers, assists tribes in their evaluation, adoption, implementation and utilization of the Community Oriented Primary Care process.
4. IHS makes public health assessment tools and technical assistance available via the tribal epidemiology centers as well as the internet.
5. IHS supports the development of appropriate public health evaluation software and its integration into the clinical data system.

**Assure that the essential public health functions are provided**

Health assurance is one of the three essential components of public health. The public health component must be combined with an appropriate direct care system to ensure the health status of a community. IHS works closely with tribal groups and organizations to assure that public health functions, as well as access to direct care, are available and accessible in AI/AN communities.

**Strategies:**

1. IHS works to improve performance of the essential public health services by increasing I/T/U access for training and continuing education in these areas. In addition, the IHS collaborates with stakeholders to develop, and distribution Indian public health training modules that are appropriate for administrative leaders, clinicians, and other staff.
2. IHS supports the development of an Indian public health Web site linked to the Indian Health Web Site. IHS works to create a mechanism that will enable best public health practices in Indian health care settings to be readily shared via the internet or the IHS intranet. This strategy includes a ready means to obtain approval of new content, and to promptly publish it electronically.
3. IHS assigns responsibility for ongoing content maintenance and improvement of this Web site to a specific entity or individual while ensuring that adequate clinical input is available.
4. IHS assures that appropriate patient/ consumer information, including health risk appraisal information, is available via the WEB.
5. The Epidemiology Centers, in consultation with the tribes they serve, develop plans through which local Indian public health infrastructures can be strengthened. The plans include the identification of resources required beyond those currently available to the Epidemiology Centers.

**Advocacy for appropriate public health**

Ongoing advocacy for public health is essential to communities. Recent events have led to an increased recognition of the critical role that adequate public health infrastructure plays in the health care arena. Maintenance of the essential public health functions is contingent upon the support and enhancement of public health. The ability to assure that community-based public health needs can be adequately met requires ongoing advocacy for appropriate public health infrastructures.

**Strategies:**

1. IHS supports the development and availability of appropriate community public health tools. Public health codes, which are usually tribally developed and enforced, are one example of this work. Currently IHS, in conjunction with CDC, has worked to identify and share model public health codes.
2. IHS advocates for adequate funding of epidemiology centers within AI/AN communities.

**PERFORMANCE MEASURES**

1. Implement community health profile in x number of communities.
2. Appropriate tribal health codes on sanitation.
3. Increased epidemiology centers and funding for these centers.
4. Percentage of local I/T/s with adequate public health infrastructure based on a standardized instrument (CDC partnership).
5. Development of a Public Health Web page.

***OBJECTIVE 1:3***

***Ensure access to information and technical expertise to define and characterize the community, identify the community health problems, and monitor the effectiveness of community health interventions.***

**PURPOSE AND OUTCOME**

Individuals and communities must become empowered. The COPC approach empowers people to work collaboratively with their own communities as well as others to identify, understand, evaluate and implement appropriate strategies to address these health problems.

The expected interim outcome is improved access to information for local decision making. The long term outcome is shared public health data in a secure environment that results in improved public health infrastructure and community health.

**STRATEGIES AND PROCESSES**

Access to public health based data must increase in order to define and characterize the health needs of our communities. In addition, technical expertise for data monitoring, data analysis, evaluation and strategy development are a critical component of improving community health.

Ongoing support for IT solutions as well as improved technical expertise in the fields of epidemiology and statistical analysis are essential components of building healthy communities.

To ensure that appropriate information is available to health leaders and to the tribes, IHS must assist I/T/U's as they negotiate data sharing agreements with States and other repositories of health information.

**Define and Characterize the Community**

One of the stated goals of a public health oriented clinical information system is improved population and public health. This objective, as well as the objectives that relate to individual health status, requires appropriate training in the acquisition, evaluation and use of data within the clinical setting.

**Strategies:**

1. IHS works to develop a process that ensures that health information is available to those who need it (current data warehouse/ data mart initiatives)
2. IHS engages in ongoing relationships with other organizations to increase access to public health data ( for example, shared immunization registries)
3. IHS works to ensure that appropriate public health information is shared in a secure manner that meets HIPAA standards
4. While assuring data security and confidentiality of *individual* information, the IHS explores ways that improved epidemiological information can be obtained through data sharing with other data repositories.

**Identify Community Health Problems**

Community health problems can be identified through a myriad number of techniques. However, most of these are dependent upon an adequate information system to obtain and aggregate individual as well as community health data. In order to identify community health problems, the information system must contain essential community information.

**Strategies:**

1. IHS continues to develop information systems that include information that can be aggregated and evaluated by community.
2. IHS develops a master person index that supports a user population that can be parsed by community of residence, as well as community of service.
3. Adequate software tools are available that function as early community warning symptoms for public health problems.

**Monitoring and utilization of data to improve public and population health**

Data must be utilized in an appropriate manner to improve health status. The integration of a performance measurement, evaluation and feedback loop is critical to improving health of individuals as well as populations. Furthermore, evidence based criteria should be used to identify appropriate clinical indictors.

**Strategies:**

1. IHS establishes an appropriate process for the development of national indicators.
2. IHS ensures that the set of national indicators share similar logic; the logic is published and available; a data warehouse is developed that includes the necessary data fields to retrieve the information essential for these indicators.
3. The IHS engages in active steps to foster national Indian public health leadership capabilities in interested Indian organizations (for example, the Epidemiology Centers, the NICOA Data Project).
4. IHS helps identify funds to specifically strengthen public health infrastructures at the local level, including funding available to non-IHS organizations with an Indian health focus that can assist with this capacity building.
5. IHS evaluates the health outcomes that result from this improved public health infrastructure.

**Ongoing inclusion of community members in data access and evaluation**

Ongoing involvement of community members in data acquisition, evaluation and recommendations is essential to improving community health status. Many AI/AN communities are involved in ongoing research projects. Community members are an essential part of the research process.

**Strategies:**

1. The IHS ensures access to adequate training and resources for data evaluation and use.
2. The IHS ensures that community members are involved in the Institutional Review Board (IRB) process, and have access to appropriate training and mentoring for IRB's.
3. The Epidemiology Centers work to provide technical assistance, including data evaluation and dissemination) to individuals and communities.

**Ongoing Support for Tribal Epidemiology and Research Capacity Centers**

The IHS-funded Epidemiology Centers and NIH-funded NARCH (Native American Research Centers for Health) serve a unique role within the I/T/U communities. These centers are able to provide appropriate coordination, evaluation and recommendations for community based health care problems. In addition, they are strategically geographically located throughout the AI/AN communities and serve as a conduit for technical and financial support from CDC and NIH.

**Strategies:**

1. IHS continues to support the epidemiology centers, and advocates for their expansion in number, scope of services, and funding.
2. IHS encourages the Epidemiology Centers, in consultation with the tribes they serve, to develop a plan through which local Indian public health infrastructures can be strengthened. The plan identifies resources required beyond those currently available to the Epidemiology Centers.
3. IHS supports ongoing collaborative efforts, such as NARCH, with CDC, NIH, AHRQ, and other government agencies to provide public health services to AI/AN communities.

**PERFORMANCE MEASURES**

1. Percentage of AI/AN communities that reach stage 4 of community oriented primary care centers.
2. Increase in number of tribal epidemiology centers.
3. Distribution and utilization of a set of guidelines for indicator development.
4. Consolidation of logic in national indicators.

# STRATEGIC GOAL 2
# Achieve Parity in Access by 2010

**OBJECTIVE 2.1**

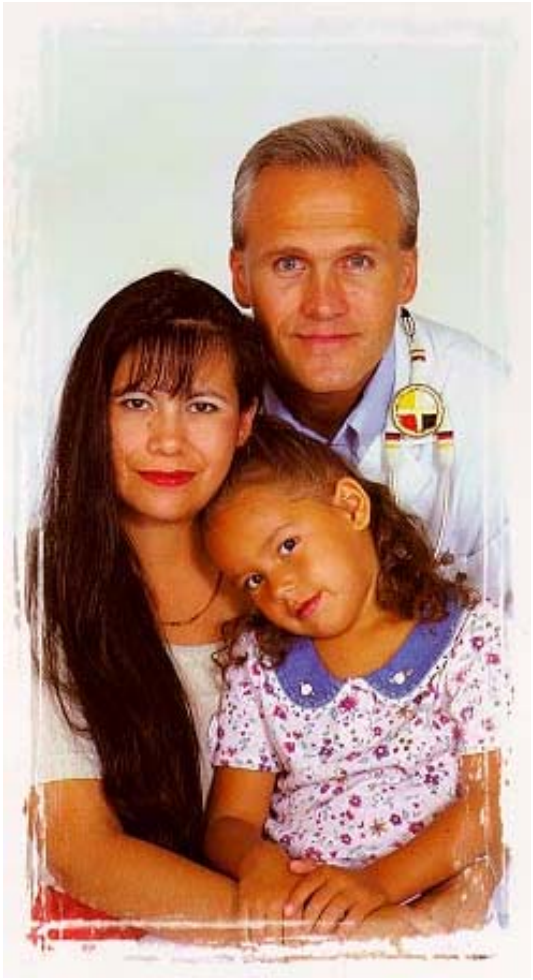
Effectively advocate for the health of American Indians and Alaska Natives.

**OJBECTIVE 2:2**

Support the delivery of comprehensive and quality Indian health care by maximizing all sources of funding and resources.

**OJBECTIVE 2:3**

Expand and maintain organizational capacity and expertise.



## To achieve PARITY in access by 2010…

American Indians and Alaska Natives will receive comprehensive and high quality clinical and preventive health care services from highly competent staff through an infrastructure of properly equipped and maintained healthcare facilities.

***OBJECTIVE 2.1***

***Effectively advocate for the health of American Indians and Alaska Natives.***

## Purpose and Outcome

Focused advocacy is one of the critical strategic opportunities. As part of this effort, IHS advocacy partners must support and unite behind the message of ***"Parity in Access to Health Care by 2010"***.

The expected short term outcome will be increased parity as demonstrated by incremental increases in access to essential health care services for AI/AN people. The expected long term outcome will be improved health status for Alaska Natives and American Indians through the achievement of parity in access to health care by 2010.

## Strategies and Processes

Indian health care has traditionally maintained a unique relationship with the Congress of the United States. The need to better inform and communicate health issues to Congress is essential. This requires the participation of all stakeholders with a consistent and coordinated message.

**Assuring Credible Data for Performance Accountability and Documenting Health Needs**

High quality, verifiable and pertinent health data on the Indian population must be accessible and shared with all decision-makers involved in the process. (also see section 3.3)

**Strategies:**

1. IHS continues to develop the data capacity and performance management infrastructure to effectively manage programs and meet accountability requirements.
2. IHS nationally coordinates, and assists the I/T/Us in the provision of high quality, verifiable and pertinent health and fiscal data.
3. IHS works to improve and expand current methods of disseminating data across the Indian health network to include a marketing approach and linkages to the local level.
4. The Indian health system provides community-specific data for advocacy for specific local health needs.

**Tribes as Leaders in Indian Health Care**

Indian tribes, in particular elected officials, play an active and leadership role in advocating for improvements in Indian health care.

**Strategies:**

1. IHS continues to facilitate tribal participation in performance planning and reporting.
2. The Indian health network develops coalitions and partnerships between tribes and interested entities (such as Friends of Indian Health) with a focus on effective advocacy.

**Establish Working Relations with State and Local Governments, and Private Organizations as well as Congress**

Partnerships and coalitions are critical to effective advocacy. These are directly addressed under Strategic Goal 4, Objective 4.2.

**PERFORMANCE MEASURES**

1. Per capita funding available for Indian health care funding.
2. Improvement in FDI (FEHB Disparity Index).
3. Increases in appropriated funding for Indian Health Service.
4. Increases in number of partnerships and coalitions.
5. Increases in funding from other sources.

*OBJECTIVE 2.2*

***Support the delivery of Indian health care by maximizing all sources of funding and resources. Implement business practices that improve efficiency and effectiveness, as well as quality.***

## PURPOSE AND OUTCOME

The purpose of this strategic objective is to support the delivery of Indian Health care in the most efficient and effective ways available to these programs. This can be achieved through an emphasis on the following endeavors:

- improving operational efficiencies
- improving collections
- securing additional funding for the construction and staffing of new health care facilities,
- securing additional funding for expansion and modernization of existing facilities and improved staffing levels.

The short term outcome will be maximized resource generation through improved business efficiencies and planning. The long term outcome will be increased and adequate access to health care services resulting in improved health status.

## STRATEGIES AND PROCESSES

### Improve Revenues

The IHS has been significantly underfunded since its inception. In order to improve health status and achieve parity with the rest of the U.S. general population, other funding sources must be identified and secured.

New initiatives must include building health care financing partnerships with outside organizations so I/T/Us can access additional resources. It is also imperative to understand the future direction of health care and health care financing to maximize opportunities and minimize threats to Indian health care.

**Strategies:**

1. IHS improves and expands its parity funding assessment for public health and community-based services.
2. IHS reviews, revises and updates the IHS Business Plan on a routine basis
3. IHS identifies existing cost accounting and cost reporting systems that have applicability to IHS for evaluation, testing and implementation ( see 3.3)
4. IHS enlists the expertise of health care economists to evaluate the economic impact of health care treatment decisions
5. IHS evaluates and improves user-friendliness of billing and accounts receivable systems for all stakeholders.
6. Cooperative efforts are encouraged with states to maximize outstationed benefit counseling.

### Limit Costs

IHS continues to recognize the need to improve efficiencies in the health care delivery arena. This is an inherent

component of improving efficiency and maximizing available resources.

**Strategies:**

1. IHS expands securing negotiated rates for Contract Health Services (CHS) with all possible vendors.)
2. The IHS routinely explores opportunities to regionalize or consolidate common activities, such as financial, personnel, acquisition and property management services.
3. IHS facilitates communication of successful business practices throughout I/T/U organizations that result in cost savings. These may include drug and supply purchasing, standardization of equipment and systems, and partnering with private and governmental sector entities for cost savings.
4. IHS develops or secures software that facilitates cost accounting and cost reporting, such as bar coding scanning systems.
5. IHS provides improved systems for strategic financial planning and feasibility analysis at all IHS sites.

**Funding From Other Organizations**

Other federal agencies, seen as potential funding sources for Indian health care programs, include but are not limited to the following: IHS's other sister agencies in the Department of Health and Human Services including Centers for Medicaid and Medicare Services (CMS), National Institutes of Health (NIH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Veterans Affairs, Department of Defense, and the Departments of Education, Agriculture, Transportation, Housing and Urban Development, Justice, Defense, and Interior. In addition, States as well as private foundations are potential sources of additional funding and shared initiatives.

**Strategies:**

1. IHS establishes a more structured process and capability within IHS to assist the I/T/Us in applying for federal grants.
2. IHS pursues other non-federal grant organizations.
3. IHS engages in partnerships with other Federal programs and outside organizations to provide staffing, training, and evaluation resources to the I/T/Us and the tribally operated Epidemiology Centers.
4. IHS works to eliminate existing barriers for accepting gifts and donations intended for Indian health care services, equipment, and construction.
5. IHS develops mechanisms to integrate services received through tribal grants with IHS.
6. The I/T/U's pursue grants for health initiatives such as substance abuse, chronic disease prevention, elder care, and women's health.

**Health Care Facilities**

A critical component of the I/T/U health care delivery system is the facility and community environmental infrastructure. The ability to deliver quality health care is dependent on having sufficient health care facilities that are properly equipped. Efforts must continue to explore all alternatives for funding.

**Strategies:**

1. IHS pursues authorities to allow acceptance of gifts and donations for construction.
2. The Indian Health Network pursues increased federal funding for new health care facilities construction to address aging/undersized/outdated I/T/U facilities.
3. The Indian health network pursues alternative methods to funding new construction, as well as equipping and staffing. Alternative methods may include increases in the Joint Venture Program, the Small Ambulatory Grant Construction Program, as well as other novel cooperative endeavors with funding and grant organizations.
4. The Indian health network promotes the need for maintenance and improvement funding increases to address the repairs, systems. replacements, and modernization of existing I/T/U health facilities.
5. The Indian health network promotes the need for increased federal funding for I/T/U locations for medical equipment replacement funding.

## PERFORMANCE MEASURES

1. The use of Contract Health Service (CHS) contracts at negotiated rates.
2. The number and scope of negotiated contracts with managed care organizations.
3. The development of new sources of funding for Indian health care that did not exist in FY 2001.
4. The expansion of appropriated funding for health delivery infrastructure, replacement of medical equipment, health facilities construction, and staffing.
5. Improvements in billing, accounts receivable and related health business systems developed and implemented.

## *OBJECTIVE 2.3*

### *Expand and maintain organizational capacity and expertise.*

**PURPOSE AND OUTCOME**

The purpose of this strategic objective is to assure organizational capacity and expertise for the Indian Health care system.

The expected short and long term outcome will be the hiring and retaining of competent, well trained employees, developing staff, and implementing processes to match sources of technical expertise/capacity to the need within the I/T/U system.

**STRATEGIES AND PROCESSES**

Organizational capacity and expertise needs of the Indian Health Network are evident at all levels. Specific competencies for local I/T/U, IHS Area or Epidemiology Centers and IHS Headquarters, are found in Appendix C.

**Staff Recruitment, Retention, and Development**

The ability to continually learn and apply knowledge is critical at all levels of the I/T/Us organizations. This capacity is not only essential to move beyond reacting to the rapid changes in medical science, information technology, and the political environment, but also to proactively seize opportunities and create the desired future of improved health for AI/AN people.

Assuring organizational capacity and expertise is the result of a combination of hiring and retaining competent well train staff as well as developing staff within the system through orientation, job experience, mentoring, and long and short term training opportunities.

**Strategies:**

1. The IHS continues support for the Executive Leadership Development Program.
2. The IHS facilitates the establishment of a coalition of IHS and stakeholders charged with the ongoing task of assessing current and future needs of the Indian health system and identifying resources from the broadest possible arena.

**Increasing Technical Capacity**

Many sources of training and technical assistance are required to address the gap that exists between current and future capabilities and needs. Potential resources to meet these needs have been neither fully identified nor utilized thus far.

**Strategies:**

1. IHS Identifies and pursues training, technical assistance and collaboration from agencies with a focus on Healthy People 2010 and racial and ethnic health disparities. For example, CDC and NIH are implementing actions to address health disparities on demonstration projects. The IHS appointee to the HHS Office of Intergovernmental Affairs is a resource can also assist in identifying and building such relationships.

2. IHS expands contacts with tribal colleges for ongoing training partnerships.
3. IHS facilitates the development of educational programs that can be shared via the Web and/or satellite to remote service delivery sites. This is done in conjunction with other federal agencies (e.g., CDC)
4. The Friends of Indian Health provide technical assistance and training in advocacy to tribes and tribal groups.
5. IHS develops an Internet-based resource list of people and organizations that have proven capacity in consulting, training, and technical assistance for specific Indian health needs.
6. Mentoring programs using retired, former, and existing I/T/U staff are established.

## PERFORMANCE MEASURES

1. Improve retention rates of health care providers.
2. Percentage of IHS Area and Headquarters staff meeting recommended training and experience standards for their respective positions.
3. Number of people completing Executive Leadership Development Program training annually.
4. The relative annual amount of training provided to I/T/U staff by non-IHS resources.
5. The number of I/T/U staff funded through IHS completing long-term training annually.

# STRATEGIC GOAL 3
# Provide Compassionate Quality

**OBJECTIVE 3.1**

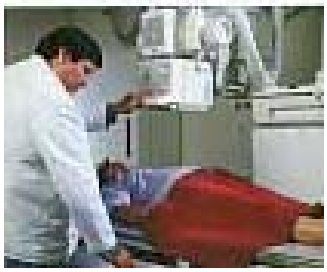
Provide comprehensive and effective health care services.

**OBJECTIVE 3:2**

Improve the safety and quality of health care.

**OJBECTIVE 3:3**

Provide quality health information for decision making to patients, providers and communities through improved information systems.



***Access to comprehensive health care services and proven interventions reduces disparity;***

***the neonatal mortality rate among AI/AN children in the IHS service population is better than the general U.S. population by 10 percent – due to effective outreach activities and accessible clinical services.***

***Objective 3.1***

***Provide comprehensive and effective health care services.***

**PURPOSE AND OUTCOME**

The provision of comprehensive and effective health care services is a critical strategic objective and is a simplified statement of the IHS Goal. The purpose of this objective is to assure access to comprehensive and effective health care services, including individual and community health services, for AI/AN populations.

The expected long-term outcomes are improved life expectancy, decreased chronic disease morbidity, and a reduction in disparity in health status of AI/AN people compared to general United States population within the next ten years.

**STRATEGIES AND PROCESSES**

The I/T/U system supports individual and public health initiatives targeting health conditions that disproportionately affect AI/AN such as diabetes. Other clinical services (dentistry), community health services (public health nursing), and behavioral health services (social work, substance abuse and mental health) are often housed in the same facilities. This co-location of services increases access and promote a comprehensive community-oriented program that maximizes the synergistic use of human and capital resources.

While these programs provide high quality services in a cost-effective manner, the full range of services is not uniformly available to all Indian people or in all Indian communities. Addressing this disparity in access is critical for the AI/AN population. There is mounting evidence that access to a usual and regular source of high quality, community based, and culturally competent care can reduce health status disparities. In addition, access to appropriate pharmaceutical interventions is an essential part of the comprehensive care delivery system.

Moreover, identifying proven, cost-effective life-style and medical interventions for those chronic diseases most prevalent in the AI/AN population, such as diabetes, obesity, and heart disease, is a critical component to the goal of eliminating AI/AN health disparities.

**Provide comprehensive health care services**

In order to meet this objective, IHS must secure adequate funding for services, facilities, and equipment, while ensuring a culturally competent, highly skilled workforce. Strategies for addressing these needs are addressed in Strategic Goal 2.

Expanding access to comprehensive health services is essential to achieving parity in access to care, both within AI/AN communities and with the general US population. The strategies listed below complement the funding and staffing strategies addressed in Strategic Goal 2.

**Strategies:**

1. The IHS facilitates the development of a recommended core pharmaceutical formulary to ensure the availability of appropriate and cost-effective treatment for all patients.
2. IHS assists the I/T/U facilities in their ongoing development and integration of measurable clinical indicators into the health care delivery system to support the goal of decreasing health disparities.
3. The IHS, in conjunction with the Indian health network, develops a model evidence-based benefits package of essential health care services.
4. The IHS, through the Indian health network, ensures the integration of essential public health services into this model benefits package.

**Pursue Research into AI/AN Health Issues**

The National Institutes of Health is making significant investments in research into the causes, prevention, diagnosis, and treatment of a variety of diseases that are prevalent in AI/AN communities. Tribal participation in NIH's Strong Heart Study, Pathways, NARCH (Native American Research Centers) and the Diabetes Prevention Program have provided valuable information on the effectiveness of these interventions in AI/AN communities.

NIH research grants, and research grants available through universities and non-profit organizations, must be tapped to identify cost-effective interventions for the diseases devastating AI/AN communities. These grants support the development of the infrastructure for disease interventions in these communities.

**Strategies:**

1. IHS proactively advocates with all Federal research grant-making agencies for Tribal participation in research grants.
2. IHS educates these agencies on the need to design grants that respond to the health needs of AI/AN communities, develop intervention infrastructure that it is sustainable within the communities at the end of the research project, and provides AI/AN with research training opportunities.
3. The Epidemiology Centers, and/or Area Offices provide technical assistance to Tribes in applying for research grants and potentially serve a coordinating role in the research project.

**PERFORMANCE MEASURES**

1. Development of a model benefits package based upon cost effectiveness and evidence based criteria.
2. Development of a recommended core pharmaceutical formulary using similar criteria.
3. Establishment of a process for routine review of the model benefits package and the formulary.
4. Increase in the amount of DHHS dollars that are appropriated for AI/AN health programs.

***Objective 3.2***

***Improve the safety and quality of health care.***

**PURPOSE AND OUTCOME**

This strategic objective requires the implementation throughout the I/T/U system of clinical and technical interventions that have been proven to improve quality of health care and the safety of patients.

The expected outcome will be increased patient safety and quality of health care as measured by consumer satisfaction as well as other evidence-based criteria (including medical error rates, facility accreditation, and health outcomes).

**STRATEGIES AND PROCESSES**

Quality of care is a broad goal that includes identification and reduction of medical errors and the integration of evidence based medicine into clinical and administrative practices. In addition, cost effectiveness analysis and technological assessment should be integrated into medical decision making at the individual, community, and population level.

**Integration of Best Practices into the Provision of Care**

Tools for accumulating and disseminating best clinical practices are critical to the improvement of medical decision-making and outcomes. I/T/U systems must work to develop access to appropriate clinical and cultural tools that can be used for work within AI/AN communities. Integrating appropriate clinical and public health best practices within the I/T/U setting will result in improved quality and safety for patients as well as communities.

**Strategies:**

1. The IHS supports initiatives that will ensure integration and access to appropriate clinical technology.
2. The IHS ensures ongoing and current access to best practices through WEB based interfaces.
3. The IHS coordinates the development, dissemination and integration of best clinical practice guidelines into the health care delivery system through the Indian health network.
4. The I/T/U system works towards integration of public health guidelines into individual patient care delivery systems.

**Assure culturally competent care**

While many patient care providers are from local communities, there are many providers who have little, if any, exposure to cross-cultural issues prior to their work within I/T/U settings. The provision of compassionate care requires an awareness of cultural issues.

**Strategies:**

1. The IHS facilitates the evaluation and compilation of current approaches to educating providers about cultural competency.
2. The IHS works with HRSA (cultural competency activity) to ensure access to other appropriate resources that can be used to achieve this objective.

3. The IHS assures that an emphasis on cultural competence is incorporated into the executive leadership training sessions.
4. The I/T/U clinical care settings ensure the integration of basic cultural competency training during orientation sessions for new health care providers.

**Implementation of quality systems**

Once best practices are developed and recognized, there must be a continued emphasis on integration and evaluation of their impact. This cycle will use a quality management approach to facilitate ongoing implementation and improvements.

**Strategies:**

1. The IHS, in conjunction with other departments within DHHS, continues to develop and support an appropriate medical error-tracking system. This system provides ongoing confidential collection, evaluation, analysis and recommendations for decreasing medical errors.
2. The IHS ensures the development and availability of provider medication order entry systems at point of care.
3. The IHS data system supports bar coding of pharmaceuticals.
4. The IHS facilitates the development and support for an electronic medical record system at point of care.

**Quality indicators**

Finally, in order to improve health status, the I/T/U system must be able to make comparisons both within the I/T/U system and the larger medical community. The adoption of comparable health outcome indicators that are used by others will help in this endeavor. For instance, incorporation of some HEDIS indicators into our work may enable us to highlight excellence and identify problem areas. In addition, there are many facilities within the I/T/U system that are models for excellence in delivery of care, as well as outcomes. These models should be recognized and shared when appropriate.

Expanding the number of quality indicators will not necessarily result in improved care. IHS must ensure the development of an overarching framework for indicator selection and the implementation of a feedback mechanism to improve outcomes.

**Strategies:**

1. The IHS provides ongoing support for development of appropriate clinical indicators that include public health priorities.
2. The IHS ensures ongoing interagency collaborations with other groups, including AHRQ and ACQA that are working on clinical indicators. This work results in the integration of the IHS indicator set to reflect national clinical priorities.

**Ensure Consumer Access to Health Information**

The known digital divide between AI/AN communities and the rest of the United States highlights the difficulties that are experienced daily by patients. Many consumers receive care in remote sites under difficult conditions. These conditions aggravate the ability of the Indian Health care system to assure access to consumer information. Increased consumer access to health information is essential to the goal of improved health status.

**Strategies:**

1. The IHS works to establish appropriate WEB based patient and consumer health information.
2. IHS' clinical IT solutions make patient education documentation easier and more integrated into the delivery of care system.
3. The Indian Health Care Network works with others to increase access to IT solutions to technologically challenged areas.

**Ensure Provider Access to Medical Knowledge and Expertise**

The continued explosion of medical information makes it increasingly difficult to maintain current clinical knowledge. It is critical that the IHS foster access to medical knowledge and expertise throughout the I/T/U settings. Improved care results from improving timely access to appropriate medical information at the point of care.

**Strategies:**

1. The IHS ensures WAN access to appropriate web based medical knowledge resources for provider use.
2. The IHS ensures that its clinical IT solutions include access to appropriate medical knowledge bases at the point of care.

**PERFORMANCE MEASURES**

1. Development and deployment of medication errors and patient safety guidelines and tracking system.
2. Integration of provider medication order entry into the clinical IT solution at x number of sites.
3. Development of a Web site that facilitates dissemination of 'best of practice; work via the Web.
4. Establish a national medical librarian position to help maintain clinical content on the IHS web page.
    a. Maintain consumer information
    b. Maintain provider content domain information
    c. Facilitate work with other agencies (National Library of Medicine, Veterans Health Administration, Department of Defense)
    d. Development of telemedicine WEB page for best practice information
    e. Development of Public Health WEB page
5. Financial support for WEB based knowledge sets that are available via the Intranet and the Wide Area Network (WAN).
6. Number of telemedicine projects that are currently established, with number of patients who use these services annually.
7. Evaluation of consumer satisfaction on an annual basis.
8. Number of providers who receive training/ exposure to cross-cultural issues within their first 6 months of work in the I/T/U setting.

***OBJECTIVE 3.3***

***Provide quality health information for decision making to patients, providers and communities through improved information systems.***

**PURPOSE AND OUTCOME**

The purpose of this objective is to assure the availability and ongoing development of a comprehensive information technology (IT) system that meets the needs of providers and consumers. This system is designed to facilitate and improve the provision of care at all levels.

The expected outcome will be that the Indian Health Network will have improved access to integrated clinical, administrative, and financial data to support individual patient care, decision-making, and advocacy.

**STRATEGIES AND PROCESSES**

The IHS can benefit from its 30 years of work in aggregating clinical information via computers. RPMS, our current clinical information system, began in 1968, and have recently been enhanced through the integration of financial and administrative data. In addition, a graphical user interface application has been released in FY 2002. This ongoing IT work is consistent with this strategic objective.

However, as previously stated in objective 1.3, the need for data within the IHS and within the I/T/U setting will only continue to increase. Data quality (accuracy, reliability and reliability), as well as quality patient care; will continue to play a highly visible role both within and outside the IHS.

Ongoing support for IT solutions will lead to the development of a more integrated system that will address the current and projected data needs, including clinical as well as administrative and fiscal

The IT solutions must be able to support the following:

- Medical decision making;
- Improved AI/AN health outcomes and quality of patient care
- Epidemiology activities to identify short- and long-term threats to the health of AI/AN communities;
- Analyses to improve the cost effectiveness of services provided
- Data to support rational budget formulation
- Data collection, aggregation and evaluation for the quality and outcome indicators needed for facility accreditation, advocacy efforts, and accountability under GPRA;
- Data to support programs seeking grants from other funding sources;
- Data that can be used for AI/AN community-directed research.

**Expand and refine current information systems**

Changes are needed to support the integration of clinical, administrative, fiscal, and infrastructure information from I/T/U facilities. This information is used to help improve the health of AI/AN people.

The Indian health network must work together to develop an information technology system and network that can share and integrate appropriate information.

**Strategies:**

1. IHS continues to provide leadership and coordination in the support and development of IT systems available for I/T/U use.
2. IHS works to ensure the availability of an integrated information system that can interface with non-RPMS applications.
3. IHS continues to engage with other agencies in development of appropriate software applications (e.g., Federal Health Information Exchange (FHIE)).

**Ensure patient confidentiality**

Policy and procedures need to be developed to ensure that the privacy of individuals is protected, while allowing transfer of information that is critical for individual as well as public health

**Strategies:**

1. The IHS ensures that our IT solutions are HIPAA compliant
2. The IHS develops and provides technical assistance in security issues to I/T/Us.
3. The IHS develops policies adequate to the electronic sharing of patient information.

**Utilization of data to improve health care delivery**

One of the stated goals of a clinical information system is improved patient care and outcomes. This objective requires appropriate training in the acquisition, evaluation and use of data within the clinical setting.

**Strategies:**

1. The IHS ensures access to adequate resources for data evaluation and use.

**Improved Data Quality and Data Sharing**

Improved data quality is and appropriate data sharing are essential to achieving this strategic objective. Ongoing and enhanced collaborative efforts help ensure that the I/T/U system can benefit from other agencies initiatives in this arena.

**Strategies:**

1. Data sharing agreements are developed with relevant State and Federal agencies, such as State Vital Records departments, State Cancer Registries and other disease registries, the National Center for Health Statistics, Immunization Registries, CMS, etc.
2. The IHS National Data Center compiles and aggregates individual and population health and service data; assure combined analysis of business and health data; generate and distribute national information reports.
3. IHS develops appropriate method for data sharing with the private sector.

**Facilitate the sharing of information from disparate sources**

There is no one solution that fits all within the clinical IT sector. IHS acknowledges that sites may choose to develop and integrate other solutions. IHS continues to recognize and support the need to develop and integrate IT solutions (both COTS- commercial off the shelf- and GOTS-government off the shelf) in a fiscally responsible manner.

**Strategies:**

1. IHS continues to develop and support ongoing sharing relationships with other federal and private organizations (e.g., FHIE, CDC Immunization Registry).
2. IHS continues to support and provide input into the medical IT standards community (e.g., LOINC, HL7).
3. IHS ensures that new internally developed software solutions are capable of capturing clinical, administrative, financial, epidemiological, and infrastructure information (see full list of data needs in the appendix)
4. IHS assures the development of WEB based applications for patient centric IT applications (ORYX).
5. Clinger Cohen Act??

**Development and Support for Fiscal Systems that include Cost Accounting**

The Division of Financial Management has implemented Method E of the Centers for Medicare and Medicaid Services (CMS) cost reporting. There are 47 cost reports to date from Area Offices and Healthcare Facilities. The current methodology allows for Medicare and Medicaid all-inclusive rate negotiations for IHS and tribal health programs. In addition, cost accounting is a CMS prerequisite for Critical Access Hospital (CAH) designation and is the basis for future Medicare outpatient Prospective Payment System (PPS) – Ambulatory Payment Classification (APC) and APG reimbursement. There is a move to develop standard cost reports as well as a data repository to allow for the integration of clinical and financial data to create standard cost reports and decision support data. Cost per Resource Value Utilization (RVU) and Common Procedure Terminology (CPT) provide a strategic advantage for cost efficiency, contract management, and utilization management.

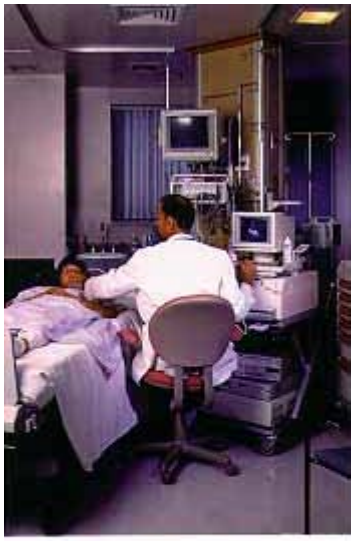
**Strategies:**

1. The IHS develops and integrates cost accounting solutions into our clinical IT package, which will interface with finance, accounts receivable, billing, data entry, coding, medical record, and patient registration, and will be compatible with PCC Plus, Envoy, Transworld, and Medicare/Medicaid electronic posting platforms.
2. Software solutions allow for inclusion of cost information, as well as other appropriate fiscal information.

**PERFORMANCE MEASURES**

1. Percentage of/T/U sites with a comprehensive IT system that allows for aggregation and export (sharing) of clinical, financial and administrative data.
2. Percentage of I/T/U sites conducting cost reporting.
3. Percentage of I/T/U sites developing business plans with identified service/product lines.
4. Percentage of I/T/U sites with Internet access for providers and patients.
5. Percentage of I/T/U sites able to extract clinical data on lifestyle components (tobacco use, alcohol use, seat belt use, etc).

# STRATEGIC GOAL 4
# Embrace Innovation



**Objective 4.1**

Expand coalitions and partnerships to build a dynamic Indian health network.

**Objective 4.2**

Become a network of innovative, creative, problem-solving organizations.

**Objective 4.3**

Improve two-way communications with patients, employees, and the network.

**Objective 4.4**

Develop an alternative organizational structure to support Indian health innovation and advocacy.

To successfully meet the first three goals in this plan, the Indian Health Network, in particular the IHS, must support an environment that promotes coalitions and partnerships. Creating and supporting a common system of communication and understanding can accomplish these goals.

***Objective 4.1***

***Expand coalitions and partnerships to build a dynamic Indian health network.***

**Purpose and Outcome**

The purpose of this goal is to establish an environment where opportunities for partnering and collaboration are continually sought and supported. Changes in IHS organizational cultural attitudes and views are essential to ensure that these collaborations are facilitated. This requires internal, as well as external, collaborative efforts. The short term outcome is to expand the network of organizations working together to improve the health of AI/AN people. The long term outcome is a comprehensive umbrella of organizations working collaboratively for to effectively contribute to and advocate for the health of AI/ AN people the realization of the IHS Mission, Goal, and Foundation.

## Strategies and Processes

The IHS recognizes that current and potential partners, as well as adequate resources, are critical to carrying out this Strategic Plan.

**Support for Coalitions and Partnerships**

**Strategies:**

1. IHS assures the development of partnership-coalition development plans at multiple levels, including national, are, and local levels.

2. IHS describes and demonstrates the importance of partnerships and coalitions to encourage appropriate consideration of such relationships in program planning and development.

3. The IHS includes objectives in annual management managers' performance reviews that will demonstrate the creation or enhancement of partnerships and coalitions.

4. The IHS establishes ways to assure that partnerships and coalitions are properly acknowledged and supported among IHS staff, e.g., the creation of an annual award for partnerships and coalitions.

5. The IHS encourages and recognizes partnership and coalition building by non-IHS entities.

6. The IHS establishes a formal feedback infrastructure to assure that input and feedback to key stakeholders and partners is accomplished in a consistent and timely manner, e.g., listserve, representation on the Indian Health Leadership Council.

7. The Indian health system forms workgroups to actively pursue potentially useful partnerships and coalitions and communicate those linkages to the rest of the Network.

## PERFORMANCE MEASURES

1. Increase in new partnership/collaborative activities implemented - nationally and reported through Area Director SES reports
2. Increase in membership of organizations such as Friends of Indian Health, Native American Caucus, etc.
3. Increase in letters of support sent to congressional subcommittees during congressional review phase of appropriations process
4. Headquarters and area level plans exist that address collaboration and that include stakeholder preferences.

***Objective 4.2***

***Become a network of innovative, creative, problem-solving organizations.***

**Purpose and Outcome**

The purpose of this objective is to create and support an environment that provides opportunities for change and improvements within the network. The long term outcome of this objective is a collaborative Network focused on innovative strategies to achieve the IHS Mission.

## Strategies and Processes

The IHS must define and implement an organizational culture where new and better methods to achieve the IHS mission are continually sought. Although a federal agency, the IHS does not have to be a bureaucracy. In fact, the IHS' decentralized organizational structure offers immense opportunity for forming and trying new ideas for improving health care and health care delivery. While the diversity of I/T/U within the Indian health network makes communication and coordination a challenge, it also provides a tremendous opportunity for pooling resources and developing innovative and creative solutions to Indian health problems.

**Strategies:**

1. The IHS increases support for creative employee solutions, including use of awards (financial as well as recognition).

2. The IHS develops a plan for program evaluation to provide a consistent approach for systematically evaluating programs, systems, processes, etc. This evaluation process shares methods and activities that work and also is a catalyst for developing new ideas.

3. The IHS establishes an annual award process that recognizes innovative programs and processes .

4. The IHS identifies and establishes a successful method for sharing of information.

**PERFORMANCE MEASURES**

1. Establishment of an awards process to recognize innovative programs.
2. Increases in the Human Resources Management Index (a quality of worklife survey) score specific to this area.
3. Increase in innovative activities reported in Area Director SES reports.
4. A New IHDT is convened that helps develop ways to facilitate and support collaborative efforts.

***Objective 4.3***

***Improve two-way communications with patients, employees, and the Network.***

**Purpose and Outcome**

Organizational structure and processes must encourage bidirectional exchange of information among partners and collaborators. The long term outcome is improved communication among partners and sharing of best practices to improve the services delivered to AI/AN patients, tribes, and communities.

**Strategies and Processes**

In addition to IHS, there are a number of Indian organizations and coalitions that work in the area of Indian health care. Information systems are still inadequate within the global Indian health network, as are feedback mechanisms.

Methods of effective communication and feedback should be established developed within the Network and implemented

**Strategies:**

1. The IHS works with other organizations of the Network to assess how current communication systems and tools can be better coordinated for information sharing and providing feedback.

2. The IHS supports development of adequate communication systems within each area and tribal officials and urban representatives.

3. The IHS supports development of area level communication policies that ensure adequate provider communication between I/T/U sites.

4. The IHS augments the use of technology and other communication channels with consistent interaction of key personnel at the Headquarters, Area, and tribal and urban program levels.

5. The IHS establishes an electronic mechanism for consistent feedback.

**PERFORMANCE MEASURES**

1. Distribution and electronic availability of consultation policy.
2. Outcome of survey on stakeholder satisfaction with consultation policy.
3. Compliance with the consultation policy (e.g., number of conference calls, meetings, etc. held with stakeholders and groups for direct interaction with IHS staff.
4. Establishment of tribal/ urban leader advisory boards within each area.

***Objective 4.4***

***Develop an alternative organizational structure to support Indian health innovation and advocacy (think tank).***

**Purpose and Outcome**

The purpose of this objective is to foster the development of visionary strategies for health care in the next century. The long term outcome is creative solutions to the pressing clinical, funding, and management issues confronting AI/AN health care.

**Strategies and Processes**

Much of the planning and work that is carried out today in the Indian health care arena is reactive in nature. The IHS and Indian health leadership have recognized the need for long term strategizing. However, the ability to be proactive on the many fronts of Indian health care has been limited by a myriad number of reasons, including insufficient funding, staff and resources. Furthermore, as issues arise, they are often dealt with on an individual basis with minimal efforts made to coordinate with other workgroups or teams set up to respond to other issues.

An Indian health think tank would provide structure and process for ongoing discussion of challenges and issues anticipated in Indian health care. The think tank would recommend strategies and actions to address these challenges, and could also serve as a bridge between proven research and analytical activities and their practical application to the delivery of health care.

**Strategies:**

1. The Indian health network identifies the expertise needed.

2. The Indian health network determines the funding support required.

3. The Indian health network acquires the funding support.

4. The Indian health network determines and agrees on working method.

5. The Indian health network establishes a think tank.

**PERFORMANCE MEASURES**

1. I/T/U agreement on establishment of think tank (number of resolutions, letters of support, etc.).
2. Amount of committed funding support for think tank.
3. Establishment of think tank.

# IHS STRATEGIC PLAN - APPENDIX A
## Workgroup Members

Members
George Bearpaw, Executive Officer
Tucson Area IHS

*Malcomb Bowekaty, Governor
Pueblo of Zuni

Rob Byron, M.D., Clinical Director
Crow Service Unit

Henry Cagey, Representative
Tribal Self Governance Advisory Committee

Nat Cobb, M.D., MPH
IHS National Epidemiology Program

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Senior Medical Informatics Consultant
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Sara Decoteau
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Sisseton-Wahpeton Sioux Tribe

Ralph Forquera, Executive Director
Seattle Indian Health Board

Randy Grinnell, Director
Environmental Health & Engineering
Oklahoma City Area IHS

Bernard Long, Health Center Director
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Carol Nuttle, Program Analyst
Office of Tribal Self Governance

Richard Olson, M.D.
Chief Medical Officer
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*Mickey Peercy, Representative
Choctaw Nation of Oklahoma

Rob Pittman, Pharmacy Consultant
Office of Public Health

Buford Rolin, Vice-Chairman
Poarch Band of Creek Indians

Glenn Safford, Representative
Great Lakes Inter-Tribal Council

Judy Sherman
Senior Congressional Liaison
Friends of Indian Health

*Anne Susan, Planning Officer
Phoenix Area IHS

Roselyn Tso, Planning Officer
Portland Area IHS

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Intergovernmental Affairs, HHS

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Phoenix Area IHS

Staff Support/Coordination
Eric Bothwell, DDS, MPH, PhD
Performance Management Consultant

Elizabeth Fowler
Planning and Evaluation Officer
Office of Public Health

Facilitator
Mary Beth Kinney

*Although originally indicating interest in serving on the workgroup, these individuals subsequently were unavailable to participate in the meetings and conference calls.

# IHS STRATEGIC PLAN - APPENDIX B
# RESOURCE DOCUMENTS

In developing this revised IHS Strategic Plan, the workgroup reviewed the following documents for: ideas on structure and format of the Plan; work that has already been done that might be incorporated into the Plan; and ideas on possible processes to use for accomplishing our work.


Department of Veteran Affairs Strategic Plan 2001-2006, September 2000

Central DuPage Health Strategic Plan, Winfield, Illinois

IHS Public Health Support Workgroup Final Report, September 1, 1999

Health Resources and Services Administration, The Access Agency, Strategic Plan FY 2000

National Indian Health Board, 2000 Strategic Planning Final Report, April 14-15, 2000

Radin, Beryl A. "Managing Decentralized Departments: The Case of the U.S. Department of Health and Human Services" PricewaterhouseCoopers Grant Report. October 1999

Radin, Beryl A. "The Challenge of Managing Across Boundaries: The Case of the Office of the Secretary in the U.S. Department of Health and Human Services" PricewaterhouseCoopers Grant Report. November 2000

Great Lakes Intertribal Council Coordinated Long-Range Work Plan – IHP/WTHDA Incorporating September, 1999 WTHDA Strategic Planning --Revised Per Mid-Course Review Priorities

Oklahoma City Area Indian Health Service, Recommendations Area Office Reorganization, July 2000, Final Draft Report

National Tribal Self-Governance Advocacy Plan for the Bush Administration and 107th Congress, January 31, 2001

# IHS STRATEGIC PLAN - APPENDIX C
# ORGANIZATIONAL EXPERTISE COMPETENCIES

**Local I/T/U Competencies**

- Clinically and culturally competent health care providers
- Appropriately trained and experienced health care managers and administrators
- IT based coding, billing, QA, and surveillance
- Community outreach HP/DP environmental surveillance infrastructure
- Tribal capabilities for budget formulation, management, marketing, and advocacy
- Recruitment and retention
- Facilities maintenance and improvement

**IHS Area Office/Tribal Epi-Center Competencies**

- Epidemiological surveillance T&TA capacity
- Health Promotion /Disease Prevention T&TA capacity
- Public Health planning and evaluation T&TA capacity
- Accountability management coordinating capacity
- IT T&TA capacity
- Contracting and procurement capabilities
- Recruiting, hiring and retention capabilities
- Business and entrepreneurial capabilities to enhance partnerships with Regional Offices, states, counties, universities, and other organizations
- Facilities planning

**IHS Headquarters Competencies**

- Budget formulation and execution expertise
- Public health policy development
- Legislative and statutory capability
- Contracting and procurement capabilities
- Public Health planning and evaluation
- Accountability management and coordinating capacity
- IT development and management
- Health economics and business management capacity
- Indian health partnership/coalition building and advocacy
- Multifaceted communication and coordination capacity
- Intergovernmental affairs expertise
- Recruiting, hiring and retention capabilities

# IHS STRATEGIC PLAN - APPENDIX D
# COMMITTEES AND WORKGROUPS

As this Strategic Plan was developed, the workgroup recognized that work related to the strategies outlined in the Plan is already being performed and that standing committees exist who will share responsibility for overseeing some of the strategies. This Appendix serves to acknowledge those entities as critical components to accomplishing the Goals of this plan.

Workgroups

Level of Need Funded Workgroup
Tribal Self-Governance Technical Workgroup
Assessments Workgroup (Centrally Paid Expenses)
Baseline Measures Workgroup
Contract Support Costs Workgroup
Tribal Leaders Diabetes Committee
User Population Workgroup II
Data Quality Action Team
Business Office Strategic Planning Workgroup
Contract Health Service Allocation Workgroup
National I/T/U Core Drug Formulary Workgroup
Priority Issue Groups

- Simplify Consultation
- Improve Human Capital
- Redesign Financial Systems
- Increase Collections
- Improve Health Data
- Increase Contributions Through Partnership

Standing Committees

Indian Health Leadership Council
Executive Leadership Group
National Union Management Partnership Council
National Council of Chief Medical Officers
National Council of Executive Officers
National Council of Service Unit Directors
National Council of Clinical Directors
National Council of Nurses
National Council on Alcohol and Drug Dependency
National Indian Women's Health Steering Committee
National Tribal Steering Committee for Injury Prevention
Facilities Appropriation Advisory Board
Information Systems Advisory Committee
National Oral Health Council